Annual Tuberculosis Screening Questionnaire

This form is to be used annually when an employee has had a positive result occur from Tuberculosis screening using either skin testing (PPD) or blood sample (QFT-G).

Name_____ Date_____

Positive TB skin test (PPD) Date:_____

OR

Positive Quantiferon- Gold (QFT-G) or IGRA date: _____

If either PPD or QFT-G (IGRA) is positive- then:

Last Chest X-Ray Date: _____ (result must be on file)

Have you travelled to or been in close contact with persons who are native to countries outside of the United States within the past year? Yes____ No____

If YES, what country/ies_____

Have you had any of the following problems for three to four weeks or longer?

1.	**Chronic Cough (greater than 3 weeks)**	**Yes_____**	**No _____**
2.	**Production of Sputum**	**Yes_____**	**No _____**
3.	**Blood-Streaked Sputum**	**Yes_____**	**No_____**
4.	**Unexplained Weight Loss**	**Yes_____**	**No_____**
5.	**Fever**	**Yes _____**	**No_____**
6.	**Fatigue/Tiredness**	**Yes_____**	**No _____**
6.	**Night Sweats**	**Yes ____**	**No _____**
7.	**Shortness of Breath**	**Yes _____**	**No _____**

Date_____ _____

Agency Employee Signature

YES NO EVIDENCE OF PULMONARY TUBERCULOSIS OR CONTAGIUM.

Date_____ _____ _____

Health Care Provider (M.D., D.O., N.P.) (print last name)